

Navy Medicine

July-August 2005



***Saving lives at
130 knots***

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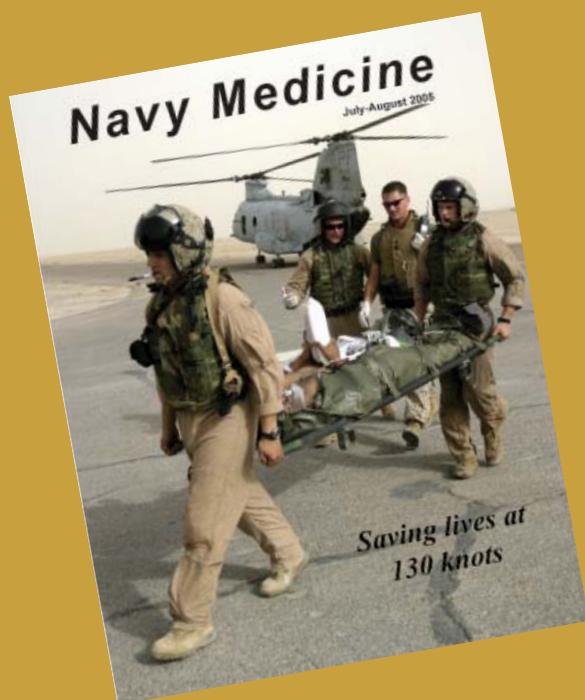
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For contributor guidelines please contact: Janice Marie Hores, Assistant Editor, Bureau of Medicine and Surgery (M09B7C), 2300 E Street, NW, Washington, DC 20372-5300 or jmhores@us.med.navy.mil.



On the cover: Patient is being transported from point of injury to Level II care unit. Photo by PFC Brian Jaques, USMC Story on page 13. **Right:** LT Philip Dauernheim and CDR Tom Craig lead the receiving assessment team. Photo by PFC Brian Jaques, USMC.

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DOD Announces BRAC Recommendations

The following Navy medicine facilities were included in the Secretary of Defense Base Realignment and Closure (BRAC) 2005 recommendations announced Friday, 13 May. These recommendations are now under review by the independent BRAC commission.

The following Navy medical facilities are relocating to Fort Sam Houston, TX:

- Naval School of Health Sciences San Diego Enlisted Training
- Medical Enlisted Basic Training from Great Lakes, IL.
- Naval Institute for Dental and Biomedical Research
- Naval School of Health Sciences Portsmouth Enlisted Training

The following medical facilities are relocating to the National Naval Medical Center, Bethesda:

- Tertiary Medical Services at Walter Reed Army Medical Center, thus establishing Bethesda as a National Military Medical Center
- Pathology Outsourcing Program Management Office at Walter Reed Army Medical Center
- Legal Medicine Program at Walter Reed Army Medical Center
- DOD Research Facilities from leased spaces in Arlington, VA, Alexandria, VA, Fort Belvoir, VA, and Durham, NC.

The following Navy medical facilities are being disestablished:

- Navy Health Care Center Groton, CT. Relocating applicable support elements to Branch Medical Clinic Kings Bay, GA, and Naval Medical Center Portsmouth, VA.

•Inpatient mission at Naval Station Great Lakes Medical Facility, converting the hospital to a clinic with an ambulatory care center.

•Inpatient mission at MCAS Cherry Point, NC, Medical Facility. The hospital will convert to a clinic with an ambulatory care clinic.

•Navy Medical Clinic at Ingleside, TX.

•Navy Medical Clinic at Pascagoula, MS.

•Navy Healthcare Center at Portsmouth, NH.

•Navy Medical Clinic at Brunswick, ME.

•Navy Medical Clinic at Athens, GA.

•Navy Medical Clinic at Navy Support Activity New Orleans.

Navy medical facilities undergoing significant changes in operations:

•Consolidating Naval Submarine Medical Research Laboratory, Gorton, CT, with Naval Medical Research Center, Forest Glen Annex, Silver Spring, MD.

•Naval Aero-medical Research Laboratory will relocate to Wright-Patterson AFB, OH.

•NAS Pensacola will gain Naval Undersea Medical Institute (NUMI) from New London, CT.

“The facilities will continue to operate, providing the same level of care and support, until the recommendations are enacted into law,” said CAPT Nancy Hight, MSC, Special Assistant for Base Realignment and Closure, Bureau of Medicine and Surgery (BUMED).

“Navy medicine fully appreciates the difficult change this will be for our military and civilian personnel, their families, and our retired beneficiaries that will be impacted by this. We will endeavor to make these base closures and realignments as smooth as possible,” she said. “Local

commands will be working directly with the affected commands and individuals to address all their concerns. Tricare benefits and access to care will be maintained.”

These proposed changes for Navy medicine are part of the larger plan of transforming DOD’s infrastructure to meet emerging missions and revised DOD strategies. The military transformation includes combining like operations of the separate services; accommodating a redeploying force structure; taking a proactive stance in answering the ever-changing challenges that face national security; providing forward capabilities in operations, training and logistics; and enhancing combat effectiveness.

According to DOD, consolidating facilities will save billions of dollars, thus allowing DOD to focus funds on maintaining and modernizing installations needed to improve support for our forces, recruit quality personnel, modernize equipment and infrastructure, and develop the defenses necessary to meet 21st century threats.

Current BRAC information can viewed at: www.bractransition.com and www.defenselink.mil/BRAC. □

—Story by Christine Mahoney, Public Affairs Office (M09BK2), Bureau of Medicine and Surgery, Washington, DC.

Techno News

For those involved in medical regulating and the medical evacuation planning of patients, take time out to explore the U.S. Air Force’s future projects like the stealth trans-

port aircraft, highlighted in *Jane's Defense Weekly* (11 May 2005, Issue No. 19, article by Michael Sirak entitled "U.S. Air Force defines future stealth transport," page 4). Called the Advanced Special Operations Forces Air Mobility Platform (M-X) it is currently under Defense Department review. The M-X is expected to have vertical or short take off and landing capabilities designed primarily for clandestine troop and supply insertion. It will have a payload capacity of 40,000 pounds and operate from runways as short as 1,000 feet. So far Boeing and Lockheed Martin have submitted conceptual designs. Members of Navy medicine involved primarily in medical evacuation must be up to speed on the latest developments in transport helicopter and aircraft technologies. It will likely be the M-X will clandestinely insert special operators and it will likely be the same aircraft that will evacuate casualties.

On the same subject of aeromedical evacuation, this month's *Jane's Defense Weekly* has a short article reporting that the Army is placing orders for additional helicopter refueling systems (11 May 2005, Issue No. 19, article by Tony Skinner, page 8). BAE Systems North America produces the Advanced Aviation Forward Area Refueling System (AAFARS). This system can be assembled at a landing zone or airfield in 20 minutes with tear-down time of 25 minutes and provides the ability for CH-47 Chinook and UH-60 Black Hawk transport helicopters to land and refuel thereby extending the range of these assets by offering a remote landing zone. This system was used effectively by U.S. forces in Iraq and Afghanistan.

For medical regulators and Medevac coordinators this offers

new options in evacuating casualties beyond the ship-to-shore range. Fleet medical administrators and independent duty corpsmen, to name a few, need to know the locations of these portable and mobile refueling systems to better grasp the evacuation options available to combat casualties through extended range transport helicopters. In addition, if casualties are onboard a flight that requires refueling at a remote location, then it may be prudent to have medical staff waiting at the site to ride in with the patient.

Finally in the great debate as to what will and should replace hospital ships in the future, *Jane's Defense Weekly* (11 May 2005, Issue No. 19, article by Richard Scott, *Jane's Defense Weekly* Naval Editor, page 14) highlights the United Kingdom's plan to scrap its intent to acquire a dedicated Joint Casualty Treatment Ship (JCTS). Less expensive options the British are now studying include: modifying one of four Bay-Class Landing Ships (LSD) to accommodate a medical facility; or chartering a hull for conversion to a hospital ship.

The British hoped to design from the ground-up a JCTS that contained 150-beds, eight surgical suites, intensive care unit, and had a speed of 18 knots. What was important to the Royal Navy in terms of a future hospital ship is a two-spot flight deck, and access of patients from the sea. This development should add to the debate of what ought to be a reasonable replacement for the USNS *Comfort* and *Mercy* in the decades to come. □

—Story by LCDR Aboul-Enein, Plans, Operations, and Medical Intelligence Officer detailed as Country Director for North Africa and Egypt, and Special Advisor on Islamic Militancy at the Office of the Secretary of Defense, Washington, DC..

CNO Names 2005 Shore Sailor of the Year

Chief of Naval Operations (CNO) ADM Vern Clark named HM1(FMF) Shannon R. Dittlinger the 2005 CNO Shore Sailor of the Year during a ceremony at the Pentagon in Washington, DC, on 26 May.

Dittlinger was chosen from among four nominees and will return to the Pentagon in July to be meritoriously advanced to the rank of chief petty officer along with the Pacific Fleet, Atlantic Fleet, and Reserve Force Sailors of the Year.

Upon receiving the honor from the CNO, Dittlinger recognized her husband, her mentor, and her shipmates, to whom she attributed much of her success.

Throughout the Sailor of the Year competition, Dittlinger has represented her former command, Naval Hospital Okinawa, Japan, where she served as the command career counselor, leading petty officer of the command color guard, and senior enlisted leader of the manpower and administrative support department.

Born in Annapolis, MD, Dittlinger was named as the Pacific Fleet Shore Sailor of the Year earlier this year. She is currently assigned to 2nd Marine Aircraft Wing, Cherry Point, NC, and will have nearly 12 years of service upon her promotion in July.

Dittlinger began her speech by recognizing the other nominees.

"Standing here in the company of the Navy's best Sailors...that in and of itself is an honor."

She said the trip to Washington, DC, helped bring the moment into perspective after she toured memo-

rials like Iwo Jima, the Korean War Memorial, and Arlington Cemetery.

“The foundation of those who have gone before us was one that was paved by honor, courage, and commitment. It was not paved alone,” she said. “My accomplishments are based on a foundation built by those around me.” □

Hospital Corpsman Earns Bronze Star Providing Combat Care to Iraqi Troops



CAPT John Sentell, MC, Commanding Officer, Naval Hospital Jacksonville, presents HMC Byron D. Rowe with his award.

HMC Byron D. Rowe was awarded the Bronze Star Medal on behalf of the President of the United States and the Joint Service Commendation Medal (with “Valor” Device) from the Secretary of Defense in a ceremony at Naval Hospital Jacksonville, FL, on Friday, 6 May.

Naval Hospital Jacksonville Commanding Officer CAPT John Sentell presented the medal and Rowe’s department head, LCDR Ethan Josiah

read the citations accompanying the medals.

Rowe is lauded in the citations for exceptional meritorious service in connection with combat operations as senior medical advisor for the Iraqi Military Academy Al-Rustamiyah and the 1st Brigade, Iraqi Intervention Force while deployed with the U.S. Army’s Multi-National Security Transition Command, Iraq (MNSTC-Iraq), in support of operations Iraqi Freedom II from 29 September 2004 to 27 March 2005.

Rowe was one of four Naval Hospital Jacksonville hospital corpsmen deployed at the time to provide similar medical support at various locations in Iraq. He was cited for delivering first class medical care to the officers and soldiers of the 1st Brigade during the Fallujah combat operations. This involved procuring supplies to outfit aid stations and training Iraqi medics on how to properly triage, treat, and stabilize wounded. He provided first-line care for more than 3,000 Iraqi soldiers and police units during the battle. Rowe’s care for the Iraqi casualties and his adherence to Muslim customs earned him the greatest respect from all the parties involved and maintained the morale of the Iraqi troops.

The citations focused on Rowe’s actions during a period between 8-10 November 2004. The Iraqi 1st Brigade troops came under fire from terrorists trying to drive them from their positions and de-synchronize Coalition Force operations. Braving incoming small arms fire, rockets, and mortars, Rowe exposed himself to enemy fire, going man-to-man encouraging the Iraqi troops to hold their ground. His encouragement to the troops and their leadership ensured that they did not withdraw and that vital staff and logistics resources

remained easily accessible to the 1st Brigade throughout the battle. □

—Story by Loren A. Barnes, Public Affairs Officer, Naval Hospital Jacksonville, FL.

Walter Reed, Bethesda Would Combine under Brac Medical Facility Proposals Concern Tri-care Advocates

From training to research to patient care, military medicine would become more joint under the Pentagon’s base realignment and closure plans.

But some lawmakers already are voicing concerns that the potential impact of the proposals on health care beneficiaries has not been sufficiently thought out.

The House Armed Services Committee wants a quick report from government auditors on how the changes might affect out-of-pocket costs for service members, retirees and their families.

The biggest changes under the Pentagon plan, unveiled May 13, would occur around Washington, D.C., and San Antonio.

Walter Reed Army Medical Center in the nation’s capital would combine with nearby National Naval Medical Center in Bethesda, Md., to create Walter Reed National Military Medical Center.

The new center would operate with a joint staff for complex and subspecialty care as the “centerpiece of military health care, clinical practice, education and research,” said

Lt. Gen. (Dr.) George Peach Taylor Jr., Air Force surgeon general. He chaired the Medical Joint Cross Service Group that developed the plan. "It will rival Mayo Clinic, Johns Hopkins and other great medical institutions of the world," Taylor said.

The BRAC plan also would affect Fort Belvoir, Va., just south of Washington, which would get a new 165-bed community hospital to focus on primary and specialty care. An expansion of Belvoir's DeWitt Army Community Hospital had been in the works, but the changes under this proposal would exceed those earlier plans.

The moves would shift 2,069 military and civilian jobs to DeWitt and 797 to Bethesda. According to Army Medical Command, about 60 percent of the jobs leaving Walter Reed would remain in the capital region.

The goal is to make the best use of facilities while improving access to patient care, officials said. Many of the beds in military hospitals around Washington are empty, yet DeWitt's patient load has increased because many military families and retirees have moved to Northern Virginia.

In addition, the plan would convert hospitals to outpatient clinics with outpatient surgery services at the Air Force Academy in Colorado Springs, Colo.; MacDill Air Force Base, Fla.; Naval Station Great Lakes, Ill.; Scott Air Force Base, Ill.; Fort Knox, Ky.; Keesler Air Force Base, Miss.; Naval Hospital Cherry Point, N.C., and Fort Eustis, Va.

Report requested

The congressional request for a Government Accountability Office report on the effects of the proposed changes on beneficiaries came from Rep. Gene Taylor, D-Miss. He said military retirees living near military

bases that closed in the past were hurt when hospitals and clinics shut down.

Taylor offered an amendment to the House Armed Services Committee's version of the 2006 defense authorization bill that asked for a GAO review of the Pentagon's medical base-closing proposals by July 1, before the Base Realignment and Closure Commission finishes reviewing the Pentagon plan.

The report would look at the potential costs to the Defense Department for off-base care and to other federal, state and local governments for each proposed military hospital or clinic closure.

The GAO also would look at whether patients would pay more, less, or the same for treatment.

Joyce Raezer, government relations director for the National Military Family Association, said military officials need to ensure that Tricare networks in areas where military hospitals or clinics might close are sufficient to meet needs. She also said Tricare Prime, the military's health maintenance organization benefit that centers largely on military installations, should remain in place in areas where bases are closing. □

—Story by Deborah Funk, Staff Writer for Navy Times.

Reprinted with permission of Navy Times. 30 May 2005 issue.

Mercy Wraps Up

The hospital ship Mercy and combat stores ship Niagara Falls completed six days of humanitarian medical assistance at Madang in Papua New Guinea on May 20.

Mercy's doctors and medical staff performed 27 surgeries, while dentists working ashore at the Asuramba and Potsdam refugee camps pulled 148 teeth. Optometrists distributed 1,092 pairs of glasses.

Navy environmental specialists tested drinking water and helped with mosquito control, while civilian mariners repaired equipment at Modilon General Hospital in Madang. Mercy and Niagara Falls, a Military Sealift Command ship, arrived off Papua New Guinea on May 15 to help victims of volcanic eruptions that occurred there in October and November, which sent thousands of residents of Manam Island to refugee camps. □

—Reprinted with permission of Navy Times. 6 June 2005 issue.

Navy Medical Library Program

Information supporting healthcare delivery grows ever more expensive. Journal subscription costs have been increasing much faster than the national inflation rate. Bringing e-journals to the deck plate is today's challenge. Efforts to lower costs while improving quality of access are described below.

Navy medical personnel have access to only some 900 online, full text journals through Telelibrary, and perhaps 10 to several hundred others through their local library. But they have to deal with passwords, less than 100 percent PDF format, and inability to access from

home. In contrast, PHS and other personnel at the NIH can access 5,000+ e-journals from office or home requiring no passwords and enjoying 100 percent PDF.

There is a solution; but a plan, agreement, and resolve are required. BUMED needs to set aside increased funding for Telelibrary with understanding by commanding officers and OICs that local library funding will be less and no local e-journals will be purchased.

A Telelibrary Committee of librarians already established, coordinated, and functioning electronically at their MTFs and sites can select content with assistance of their provider staffs, and keep links activated so that searchers can read results of their searches.

All NAVMED personnel accessing one library computer system being developed containing a union catalog of MTFs' library holdings will facilitate optimum information exchange. Vendor hosted, it can be an ".edu" site enabling access from home.

A commitment from Navy and military healthcare providers to join NIH funded authors in submitting published papers to PubMed Central of the National Library of Medicine will lower costs of obtaining archived knowledge based information.

Jerry Meyer, Director
Navy Medical Library Program
E. R. Stitt Library
National Naval Medical Center
Bethesda, MD 20889-5600 □

House Committee Slots \$2.2b for Vets' Mental Health

The members of Congress who decide how money is spent are focused on the mental health care of veterans, particularly those returning from combat who may suffer from post-traumatic stress disorder.

In an unusual move, the House Appropriations Committee has fenced off \$2.2 billion in the Department of Veterans Affairs budget for specialty mental health care "to be assured that funding for mental health care will not be siphoned off for other purposes," committee members said in an explanatory report on their budget recommendations for fiscal 2006.

VA officials have estimated they will spend at least that much on specialty mental health programs the next fiscal year, and up to \$10 billion for health care spending for all veterans who have mental illnesses.

The committee's version of the 2006 defense appropriations bill also directs the Pentagon and the VA to jointly study mental health care, including PTSD, panic disorder and bipolar disorder.

PTSD must be identified early to prevent it from becoming chronic, a mission made more critical by the fact that a new generation of combat veterans is seeking treatment.

To do that, the VA could use data from the Pentagon's post-deployment health screenings, to which the VA

now does not have access. The committee directed the Pentagon and VA to tell Congress what, if anything, prevents sharing that data and to suggest remedies.

House appropriators also want the VA to come up with a plan that would put PTSD clinical teams at every VA medical center. About half of the VA's medical centers now have them.

The appropriations bill also would require the VA to establish a new classification of psychiatric nurses, said Rep. Marcy Kaptur, D-Ohio.

The committee also is directing the Waco (Texas) VA Medical Center, which the committee calls "a national resource in psychiatric care for veterans," to work with officials at Fort Hood, Texas, to study PTSD. The Pentagon funds stress-disorders research at Hood, according to the report.

The committee recommended a total of \$68.1 billion for the VA next fiscal year, \$21 billion of that for health care programs. The health care appropriation is \$1 billion more than the Bush administration had sought for the VA and more than \$1.6 billion above this year's budget.

Still, veterans' groups say that is not nearly enough. Some advocates say the VA needs \$31.2 billion to fully meet the health care needs of the nation's veterans.

Disabled American Veterans National Commander James Sursely said many VA facilities already are running out of money with four months still left in the fiscal year that ends Sept. 30. □

—Story by Deborah Funk, Staff Writer for Navy Times.

Reprinted with permission of Navy Times. 30 May 2005 issue.

NMCSD's Fisher House is "Home Away from Home" to Military Families

Gene Nabers was in her Memphis, TN, home when a phone call turned her world upside down. Her youngest child Michael, a 23-year-old Marine private first-class, had just been admitted to Naval Medical Center San Diego's (NMCSD) intensive care unit. Nabers was 2,000 miles away and felt helpless.

"My mind went blank. I panicked," she said. "I just knew I had to get there as fast as I could."

Nabers bought a plane ticket, packed a week's worth of clothes, and arrived by Michael's side the following morning. She had little spending money—just money she was able to save from her teacher's salary—and had nowhere to stay while NMCSD doctors treated her son for a life-threatening infection that was spreading throughout his leg.

Not wanting to leave the hospital for fear of leaving her son's side, Nabers wasn't sure where she'd sleep. "I would have slept on the hospital floor if I had to," Nabers said.

Fortunately, a nurse at NMCSD overheard Nabers' dilemma and recommended Fisher House.

Fisher House, a "home away from home" for families of active duty and retired service members' families, was Nabers' alternative to the hospital's cold, tiled floor.

With 29 locations throughout the country, including the one in San Diego, Fisher House is located on the grounds of military medical centers and Veterans Hospitals, allowing guests to be within walking distance of their loved ones. The houses were donated to the U.S. Government by philanthropists Zachary and Elizabeth Fisher, long-time supporters of

the military, as one way of giving back to their country.

"Staying at Fisher House is like staying with family," said Nabers, who has stayed there on and off for more than 6 months.

The cost to stay at the Fisher House is only \$10 per night per family. For Nabers, whose finances were severely strained from flying back and forth from Tennessee to California, the price and location were an enormous help.

"I don't know what I would have done if I had to stay at a hotel," said Nabers. "I just couldn't afford cab fare, food, and hotel fees. Fisher House feels like my home."

The home-like setting had the desired effect as the house boasts a kitchen and living room with fireplace. A washer and dryer are also available.

Small details such as photos, a library, and permission to treat the house "like your own" add to its hominess. Each room has private telephone lines to receive emergency calls from the hospital. A small backyard equipped with a children's playground can be seen from the house's rear windows.

A brick walkway leads to a picnic area complete with a gas grill and gazebo. San Diego's Fisher House is also the only one to have a wheel chair accessible staircase as a means to reach the second level.

"Once you're here, you're considered family," said NMCSD's Fisher House Housing Manager David Esposito. "We try to make every guest feel welcome by talking to them and letting them know we're here to help."

Though the Fisher House program was established almost 15 years ago, Esposito said few military families know of its existence. He's often gone beyond his duties as a manager by contacting families visiting NMCSD patients himself to offer them a room. "We try to eliminate some of the stress and hardships our guests endure," he said. "We're trying to get the word out about Fisher House to let people know we take care of all branches of the military."

Esposito said families who stay at the house have varying reasons, from wanting to be closer to their premature baby to supporting their 30-something-year-old spouse undergoing physical therapy.

Esposito added that with not a lot of publicity, Fisher house relies mostly on private donations for upkeep. "We can always use things like frozen foods, such as TV dinners, clothes for premature babies, prepaid telephone cards for the guests, and bedding," he said. Donations enable Fisher Houses to continue helping more families like the Nabers.

To contribute to the Fisher House, contact Esposito (619) 980-7784 or log onto www.fisherhouse.org for more information. □

—Story by JOSN S.C. Irwin, Navy Journalist assigned to the Navy Public Affairs Center at Naval Station, San Diego, CA.



Fisher House, NMC San Diego.

Mobile Dentistry in OIF II

Mobile dentists in Iraq? All in a day's work for several dentists of the 1st Dental Battalion (1st FSSG) who helped provide dental care for Marines of the 1st Marine Expeditionary Force (I MEF) during OIF II from March to September 2004.

1st Dental Battalion, led by Commanding Officer CAPT Paul A. Lindauer, implemented the idea of using mobile dental teams to reach a patient population of some 24,000 Marines scattered over 500 miles. The teams, comprised of one dental officer and two dental technicians (DTs), were equipped with the Navy's ADAL system, a self-contained field dentistry suite including a portable compressor, sterilizer, digital X-ray equipment, patient chairs, and suction unit.

Arriving in Iraq via Kuwait in February 2004, the "Scarlet" dental detachment, lead by CDR Dave Rupprecht, DC, established two dental clinics at AL Taqqadum, less than 30 miles from Fallujah. Dental personnel borrowed power tools from departing Army units to help construct an outdoor patient waiting room that was eventually enclosed and included air conditioning. Generators, provided by Marine units, provided power for the dental equipment, while local power was also used.

Once the clinics were up and running, the mobile teams were assigned areas of responsibility. LT Mark J. Glasgow convoyed to areas in and around Ramadi, including Marine bases at Blue Diamond and Hurricane Point. LT Heather Gnau was assigned to Fallujah and the forward operating bases (FOBs) near Mudyasis and "Korean Vil-

lage," an isolated Marine camp not far from the Saudi Arabian border. I made two trips by helicopter to Al Qaim, near the dangerous Syrian border, to provide care for the 3rd Battalion, 7th Marines. Dr. Rupprecht, the DET's OIC, also made a month-long trip to Korean Village to provide mobile care to elements of 3rd Battalion, 4th Marines. LCDR O.J. Fugaro, a clinic director at Al Taqqadum, spent 1 week at Ramadi providing exams for leathernecks of the 3rd Battalion, 4th Marines.

All the mobile dental teams faced challenges. Procuring generators and securing power for the dental equipment and air conditioning became an exercise in itself. Marines made every effort to secure "clinic" space for the dental teams before they arrived, which at times included concrete structures, tents, and portable trailers. But like everything, improvisation was the order of the day. Deployed units in Iraq requested dental support via the FSSG website but word of the mobile dentists spread fast. Focusing primarily on care to Marines, mobile dental teams also provided dental care for Army personnel, and occasionally U.S. Government contractors.

When not being shelled by mortars, avoiding roadside bombs, and Chinese rockets, the mobile dental teams provided routine cleanings and fillings and emergency treatment for Marines suffering facial trauma from improvised explosive devices (IEDs). The blast force from some



Photo by DN James Jarreau, USN

Dr. Tully at work in Iraq.

IEDs was strong enough to dislodge, and in some cases completely knock out tooth fillings.

In September 2004, the "Scarlet" team was relieved by dental team members of the "Gold" team lead by CDR Jonathan Haun. Mobile dentists included LCDR Raoul Santos, LT Bret Mangum, and LT Huang. All made trips in and around I MEF area of operations to provide dental care to Marines.

"It really made a difference," noted LT John Huang, who provided dental care to 1st Battalion 7th Marines in Al Qaim. "We helped prevent non-battle casualties and did whatever it took for the warfighter—the Marine on the ground." □

—Story by LCDR Brendan Tully, DC, staff dentist, Marine Corps Air Ground Combat Center, 29 Palms, CA.

Navy Medicine Operates in Austere Conditions

The first tent you see after the dust settles and you step off the helicopter is the BAS Medical tent—Battalion Aid Station—home for the last 3 months for CDR Gayle Myers, NC, and HM1 Bobby Huddleston.

The temperature is about 95 degrees in the afternoon and it has only rained three times in the 3 months they have been here. No, it is not Iraq but Gonaives, Haiti, site of New Horizon (NH) Haiti 2005.

New Horizon is a humanitarian exercise sponsored by U.S. Southern Command, in Miami, FL. The exercise provides engineering and humanitarian assistance to an area of Haiti hit particularly hard by last year's Hurricane Jeanne.

The exercise combines the four armed forces to conduct humanitarian construction projects and provide medical care to the people of Gonaives. Personnel built three schoolhouses and drilled three water wells. Medical teams from the Air Force, Army, and Navy provided care to over 15,000 patients during the 3-month period.

But for the more than 1,000 U.S. armed forces personnel that have rotated in and out of Camp Unity, the U.S. base camp in Gonaives, medical care came from within the wire surrounding the camp.

The combined efforts of Myers, the Adult Nurse Practitioner and Huddleston, the corpsman provided Level 1 medical care to over 200 service members. "We didn't have any serious injuries," said Huddleston. "Some heat stress and sprained ankles. We have been pretty blessed."

The job cutout for Myers and Huddleston and their major success was to keep the Task Force healthy. The health risk assessment for Gonaives indicated a high potential for mosquito-borne diseases like dengue or malaria, as well as airborne and gastrointestinal diseases.

A rigorous safety program helped keep all the Sailors, Marines, Airmen, and Soldiers aware of potentially dangerous situations and reminded them to stay focused on safety. "Our job was really preventive medicine," said Huddleston. "We encouraged everyone to keep up their care—washing hands frequently, drinking plenty of water, and getting enough rest."

Not only did the medical team keep all the exercise participants healthy, but they also helped support three medical readiness training exercises (MEDRETE). The MEDRETEs provided care to over 15,000 Haitian patients during the 3-month period. The medical teams from the Air Force, Army, and Navy rotated into the camp, one team at a time.

The logistics of supporting over 60 medical specialists was tremendous. "Whatever we have accomplished," said COL Andre Henry, officer-in-charge of the Army medical units, "was due to CDR Myers' efforts here on the ground, paving the way for us to succeed." She really coordinated all the medical supplies and arranged transportation to get the teams to the medical evaluation sites and back, safely and quickly.

While for the Construction Battalion based corpsman Huddleston working in the field is a routine oc-

currence, for Myers, working in the field was a new experience.

"We (Seabees) do 21-day field exercises all the time," said Huddleston. "This is just a 3-month field exercise—yet an important one for the people of Haiti."

For Myers, a Maine native, the heat and dry conditions of Haiti took some getting used to. "Actually I never got used to the heat," said Myers. "I like it cool. I can't wait to get back to Maine," smiled Myers. "I miss the cool weather and especially the seafood. We haven't had much here."

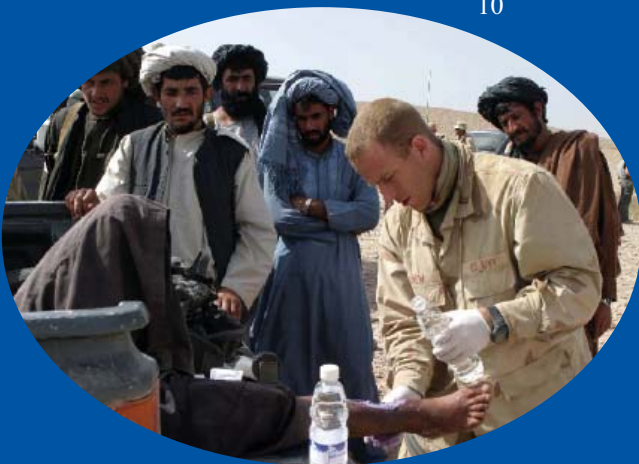
Because of the primitive sanitation conditions, everyone ate Meals Ready-to-Eat (MREs) supplemented by hot meals at dinner—UGRs (Unitized Group Rations)—and occasional airlifts in of fresh fruits and vegetables.

The BAS medical team was the only reliable healthcare between Gonaives and Port-au-Prince, a 60-minute round-trip for the Port-au-Prince Army helicopters. "We provided Level 1 care here," said Myers. "If or when we had to, we transferred patients to the MINUSTAH (United Nations) Level 2 care facility in Port-au-Prince."

"If someone needed more extensive care, the nearest U.S. facility is 2-3 hours away at Guantanamo Naval Base, Cuba," noted Myers. "So it was really important that we were ready to stabilize a patient here and get them proper care quickly."

The mark of a successful exercise is when no one is seriously injured. For this Navy medical team, the long hours, dusty conditions, and tropical diseases in the area were a challenge, but a challenge that was clearly met. □

—Story by CDR Dan Bates, Task Force New Horizon Haiti 2005's Public Affairs Officer.



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1. Nias, Indonesia. DT3 Ryan Hill teaches students the proper use of a toothbrush at a school on the island of Nias. Photo by JO1 Joshua Smith.

2. Madang, Papua New Guinea. HM2 Anthony Ecija performs an ultra sound on a patient at the Modilon General Hospital. Photo by Ph2 Sandra M. Palumbo.

3. Nias, Indonesia. LCDR Daniel Cuellar ensures that a patient's helmet is properly adjusted before she is medically evacuated to the USNS *Mercy* (T-AH 19). Photo by Ph2 Sandra M. Palumbo.

4. Najoy, Afghanistan. LCDR Gary Martin, left, and U.S. Army CAPT Brad Frey evaluate a severely malnourished Afghan infant. Photo by GYSGT Keith A. Milks.

5. Potts Dam, Papua New Guinea. HN Jessica Mayer preps a syringe filled with measles, mumps, and rubella vaccination before injecting a local woman. Photo by Ph3 Lamel. J. Hinton.

6. Najoy, Afghanistan. HM3 Lori Butierries tells Afghan children to wait their turn for a piece of candy. Photo by GYSGT Keith A. Milks.

7. Kharma, Iraq. HN James Sanchez inventories medical supplies outside a home during a routine patrol of a local neighborhood. Photo by LCPL Matthew Hutchison.

8. Al Ubaydi, Iraq. HM2 Jenkins treats a burn on the leg of a young Iraqi boy. Photo by CPL Eric C. Ely.

9. Manama, Bahrain. Dental Hygienist Liza Siwa conducts a routine cleaning in the Naval Branch Health Clinic at Naval Support Activity, Bahrain. U.S. Navy photo.

10. Oruzgan Province, Afghanistan. SMO, LT Brendon Drew treats an injured Afghan Militia Force soldier for burns. Photo by GYSGT Keith A. Milks.

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Deputy Surgeon General Retires After 32-year Navy Career

The Bureau of Medicine and Surgery (BUMED) wished their Deputy Surgeon General, RADM Kathleen Martin, NC “Fair Winds and Following Seas” on Friday, 27 May 2005. Martin retired from the Navy after fulfilling over 32 years of devoted and committed service during a ceremony held at the Washington Navy Yard.

“I took my career one tour at a time. Every time I was at the end of a tour and looking at possibly getting out of the Navy, I would get an offer for another different and challenging assignment, so the Navy hooked me each time,” said Martin. “It was not until I was in San Diego and a senior LCDR that I realized all of the sudden I had made a career out of this. I was already at the 15-year point before I realized that when people would say ‘career Naval officer,’ they are talking about me. Until that point, my career had been one tour at a time, one assignment at a time, one challenge at a time.”

Martin arrived in the National Capital area in August 1998. During her first few years in Washington, she served as the Medical Inspector General and the 19th Director of the Navy Nurse Corps. In November 1999, she served as Commander, National Naval Medical Center. Martin came to BUMED in 2002, assuming the role of Deputy Surgeon General.

During her college years, Martin joined forces with the Navy. She earned a nursing degree from Boston University in 1973 through the Navy Nurse Corps Candidate Program. This fellowship program provided Martin with the education she needed to become a nurse, while requiring a one-tour commitment to serve upon graduation.

Martin’s first duty station assignment was at the Naval Hospital at

Camp Lejeune, a Marine base in North Carolina, not a huge, gray Navy ship she was expecting. “It was a shock to me that I could even get orders to a Marine Corps base because when you think of the Navy duty assignment, that was not necessarily one of the assignments that you think of,” she said. “When I received my orders, I thought they made a mistake. So when I went to seek clarification, that is when I was educated that Navy medicine takes care of both the Navy and the Marine Corps.”

Camp Lejeune was a different world. Martin said that during her working hours at the hospital, she was able to apply what she had learned at OIS to her job. However, Martin added, when she went outside the hospital and was in the Marine Corps environment, she did need to be educated and aware of the Marine Corps culture.

“The hospital realized there are individuals coming in who knew little about the Marine Corps, so they put us through an orientation program. Not only did it take a while to become attuned and acclimated to wearing a Navy uniform, but then realizing that this was a unique experience because it wasn’t a Navy experience, this was a Marine Corps experience,” said Martin. “At that time, we had small operational units that went out with the Marines. Never did I realize, nor never did I ever think I would be going out into a field hospital environment on operational exercises. When I was an ensign, I always thought I would find myself on shipboard someplace eventually. So my first experience in the Navy was actually living in a tent.”

With a career on the fast track, tour assignments included Pearl Harbor,



San Diego, and Port Hueneme, CA. In 1993, Martin took her first Commanding Officer (CO) assignment as the CO of the Naval Medical Clinic at Port Hueneme, CA. Subsequently, she served as CO at the Naval Hospital in Charleston, SC, from July 1995 to July 1998.

Managing a Naval career and a personal life can be quite a challenge, but not impossible. “I felt I had a very good balance between career and home life because my various challenges in assignments probably came at the right times in my life,” she said. “When I moved to Port Hueneme, my husband retired, so I had wonderful family support. Maybe it was our timing and the type of assignments that were just in the right locations that I happened to get.”

According to Martin, though she is retiring from her naval career, that does not mean her work ends here. “I am going to seek another career that is personally satisfying to me. I’m not going to look for something that will put me back in the rat-race, but something that is very rewarding, satisfying, and challenging,” she said. □

—Story by Christine Mahoney, Public Affairs Office (M09BK2), Bureau of Medicine and Surgery, Washington, DC.

Hit the Ground *Flying*

LT Corey A. Jago, NC, USNR
LT Michael A. Buckley, MC, USNR
CAPT Kevin J. Knoop, MC, USN

Research has suggested that rapid transport of critically injured patients for surgical intervention could improve the chances for survival. The En Route Care System was developed to ensure the safe transport of these critically injured patients postoperatively. The mission uniquely provides continued resuscitation and critical care in the aviation and combat environment.

CASEVAC to TQ Surgical

Some say the waiting is the hardest part, but here at Camp Taqaddum, Iraq, known locally as “TQ,” the work that follows the waiting is guaranteed to be even harder. But first, corpsmen in the casualty evacuation (CASEVAC) shack and the aircrew in the Ready Room wait for the high-pitched ringing bell signaling an “Urgent CASEVAC” has just been initiated. They wait for a chance to save a life and they hit the ground flying to do so.

First, the Operations Duty Officer (ODO), receives notification of the mission by either secure phone or a text message monitored 24-hours a day, 7-days a week. While still on the phone, a “thumbs up” means the game is on and the runner rings the bell.

Once that bell rings, the routine suddenly becomes urgent for the aircrew and corpsmen assigned to the world famous “Purple Foxes,” a Marine CH-46E

squadron with a long medical evacuation (MEDEVAC) history. The squadron is the lone CASEVAC squadron for their Area of Operations in Iraq. A second USMC squadron provides fire support during the missions. Although the ringing of the bell officially activates the 30-minute stand-by, everyone scrambles. Pilots, aircrew, and corpsmen hustle to their assigned aircraft. No time is lost in the launch sequence, for time lost is life lost.

An Army “9-line” message relayed from the TQ Air Boss calling for helicopter transfer of an injured person results in an urgent CASEVAC or MEDEVAC. (CASEVAC is the removal of casualties from the battle-



Photo by LCPL Tasha Fontaine, USMC

OIF III Camp Taqaddum Surgical Shock Trauma Platoon



HN Millan expediently loads the most critically injured patient first.

field and MEDEVAC is the medical evacuation of patients from one level of care to another.) The wounded person could be a friendly, enemy, or civilian. The message can originate from almost anywhere—troops in a fire fight, a Level I aid station, or even a post-operative patient out of TQ Surgical's Level II operating room.

The clock begins running and the helos are started while the ODO continues collecting pertinent data including point of origin, destination, frequencies, and call signs. Simultaneously, the Battle Captain crunches all the factors and evaluates the situation in order to make a risk assessment between the lives of the aircrew and the casualty of war. Once the ODO receives this "Battle Captain Approval," he passes the information to a runner who immediately relays the mission assignment to the turning aircraft awaiting taxi and takeoff.

The call on this hot spring day alerts us that there are two "Urgent Surgical" litter-bound patients and two ambulatory "Routine" patients at the point of injury (POI) needing evacuation. There are four patient severity categories: **Urgent** or **Urgent Surgical**—medical or surgical care required within 1 hour to prevent loss of life or limb; **Priority**—requires medical care within 4 hours to prevent loss of life or limb; **Routine**—not life- or limb-threatening but should be treated within 24 hours.

The injuries were caused when an insurgent's vehicle-borne improvised explosive device (IED) detonated on a road to Ramadi, located at the base of the Sunni Triangle, a hotbed of insurgent activity. The call is transmitted to the Direct Air Support Center (DASC) and

the Patient Evacuation Team (PET), both co-located at Camp Ramadi. The PET makes a quick medical assessment considering many factors, including the number and nature of the injuries, time to the nearest facility, and the most recent data on which facility in-theater is capable of receiving the casualties and treating their specific injuries.*

The DASC considers tactical factors such as location, nearest available resources, and friendly/enemy situation at the landing zone (LZ). After a critical mass of information is collected, the request is made for approval to launch the aircraft. Time is of the essence, as any delay in launch delays lifesaving care. It takes approximately 15 minutes for the call to reach us, most landing zones are within 20 minutes, and from time of injury to time seen in a Level II or III facility is usually between 1 hour and 1 hour 40 minutes.

You can sense some tension in the aircraft as we speed toward the objective. The incoming information tells us how many casualties to expect. Today we are going to a point of injury instead of a Level I facility. Even with

*Level I care is defined as anything from buddy aid to a BAS (Branch Aid Station) containing corpsmen and a physician assistant or medical officer. Level II care provides rapid surgical or resuscitative care with anesthesiologists, surgeons, and emergency medicine doctors but limited facilities for convalescent care. A Level III facility employs many medical specialists, is able to provide limited inpatient services, and is the highest level of care in theater. If patients are not returned to duty, they are sent on to a Level IV facility in Europe or CONUS.



HM3 Hess diligently maintains IVs and monitors the patients vital signs.



An eager STP crew meets the ambulance.

the haze and dust of the desert, after about 15 minutes of flight, we are able to see the orange smoke grenade marker from several hundred meters out.

After landing, the pilots are ready to take off again at a moment's notice if the current situation changes and places the helicopter and crew in harm's way. The aircrew continuously scans the area with their .50 caliber machine guns.

Two corpsmen race out of the aircraft going straight to the patients. They now rely on their specific training despite the danger. There have been occasions where small arms fire and rocket propelled grenades (RPGs) have been fired at the helicopters in flight and on the ground, so the corpsmen need to remain close.

One corpsman extends out to the end of his communications cable just outside the aircraft and the other runs to the obvious casualty on a stretcher surrounded by Marines and their corpsman. The CASEVAC corpsman attends to the most seriously injured, knowing they will be loaded into the aircraft first. The corpsman's job is very difficult because he is required to perform several functions efficiently and simultaneously, often under very austere and stressful conditions. He then must triage the casualties and assess airway, breathing, and circulation, along with the entire body in case there are any "hidden" wounds to be addressed in-flight.

Most importantly, all tasks must be completed as fast as possible because time is of the essence, and no LZ is safe. Once on the helicopter, further assessment

is very difficult with the noise, vibration, and wind that comes with travelling at 130 knots.

One of the casualties is badly injured. The ground units' corpsman has dressed his wounds but there is already blood soaking through the dressings. Dirt and soot cover his face which is twisted in agony; the first dose of narcotics administered on the ground has not had any effect. A cryptic note scribbled on his bandages alerts subsequent providers to the amount and time of medications given thus far.

The second Marine appears to be less seriously injured than the first, but not by much. Both corpsmen busily attend to the patients. The basics of an accurate visual survey could not be more significant at this time, considering the wind is intense and one must shout to be barely heard. In this case, both patients have decent color and appear to have adequate air exchange, since they can speak when questioned. Pulses are strong where palpable. The Marines received morphine, but they are still complaining of intense pain. The corpsmen must consider vital signs before administering additional potent pain medications.

The honed skills and teamwork executed by the CASEVAC team have allowed these casualties to arrive safely and in stable condition at the critical next level of medical care. An ambulance and corpsmen are waiting



Photo by GYSgt Robert Butler, USMC

CDR Tom Craig and the STP triage team quickly reassess the patient's airway, breathing, and circulation.



The operating room stands ready to receive 24/7.

as the helo touches down. The patients are transferred and the crew and corpsmen are allowed a brief sigh of relief as they bask in the satisfaction that they helped save lives that day.

TQ Surgical

Located inside Camp Taqaddum in the heart of the combat zone is TQ Surgical. The Surgical Shock Trauma Platoon or “SSTP” is a non-doctrinal combat medical mission comprised of surgeons, anesthesiologists, emergency physicians, nurses, corpsmen, and Marines. Its combination of several component systems include a Forward Resuscitative Surgical System (FRSS), one Shock Trauma Platoon (STP), and half of another. This combination makes for a surgical and resuscitative capacity not previously envisioned. It is the busiest Level II trauma facility in theater. Patients arrive mostly via helicopter, but about 25 percent come by ground vehicles, sometimes speeding unannounced up to the SSTP with their wounded. Both friendly and unfriendly casualties have been treated at TQ Surgical. All receive state-of-the-art care, and today’s arrival is no different.

The flight line ambulance pulls to a halt and a triage officer makes the initial medical assessment. The patient is off-loaded to a staging area where an emergency medicine physician continues the evaluation. An assigned Marine labels each new patient by writing a number on the left shoulder. This number will identify all information about the patient while at TQ Surgical. The initial triage decision on the staging

pad determines if the patient has a clear indication for surgery. If an operating room (OR), including personnel, is ready, the patient is moved immediately to the OR. Alternately, if the OR rooms are busy, or if the patient needs stabilization prior to surgery, personnel move him to the STP tent.

Once inside, a crowd seems to descend upon each patient. Stretcher bearers transform into functioning corpsmen as a nurse joins the team. Medical staff and clergy from nearby units join in as well. They are an integral part of the team. Vital sign monitors are attached and two IVs started. Simultaneously, the EM doctor or physician assistant comb over the patient to quickly confirm the findings obtained on the pad and complete a more thorough assessment and physical exam. An abdominal sonography for trauma exam is performed and X-rays are ordered. Stepping back, the scene looks chaotic, but the motions are a symphony of state-of-the-art medical care being delivered.

Litter bearers transport the patient to the surgical tent. They make this move look easy, as the tubes entangled in all the gear are swept along with the litter. The OR team is ready, and again a throng descends on the patient. The area is prepped for surgery, instruments are prepared, blood is cross-matched and, if necessary, a walking blood bank is activated, a process that brings hundreds of personnel in the camp out to donate precious blood. With



What appears to be chaos is actually well-orchestrated patient care.



In the desert heat, the walking blood bank donors rehydrate.

the surgeons scrubbed and monitors attached, surgery is now ready to begin.

Because there is more than one surgeon present, in addition to an orthopedic surgeon, OR times can be kept relatively low. For example, three surgeries that might be needed on one patient that would take 1 hour each with one surgeon, might be done in less than 1 hour with two. When multiple patients present needing surgery, there is capacity to expand into another OR and do a more limited or “damage control” surgery. This allows higher capability for more patients in mass casualty situations. This flexibility is why TQ Surgical is unique and makes the whole greater than the sum of the parts.

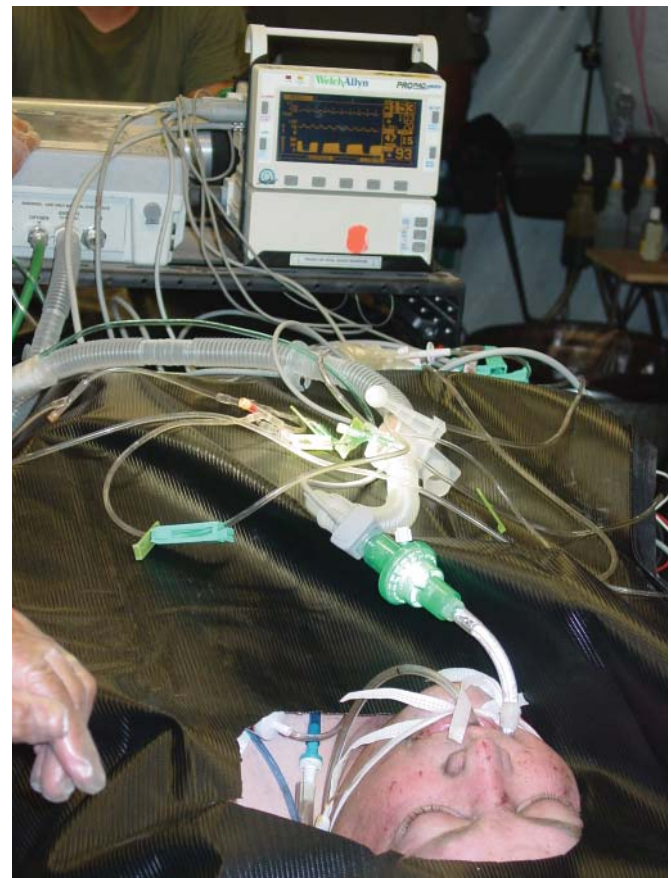
As surgery is completed, preparations are made to get the patient ready for travel to the next level of care. Being close to the front has its drawbacks. One is that our helicopters are targets during the daylight, a risk assumed by the crew when an urgent transfer is needed. All non-urgent transfers are made at night. An SSTP nurse jumps into a flight suit and morphs into an En Route Care (ERC) nurse. The ERC nurse also dons protective gear, a weapon, and gets the final report from the surgical team prior to departing with the patient.

The capacity for rapid lifesaving surgery is the “raison d’être” of a Level II facility. Patients with exsanguinating injuries would not survive a longer transit time to a Level III facility. One such patient arrived without advance warning. Struck by an IED fragment that penetrated just below his collar bone, his subclavian artery and vein were severely torn. He arrived near death, just minutes after the injury. He rapidly underwent intensive stabiliz-

ing surgery to control the bleeding from the shredded subclavian vessels. Within 15 minutes of his arrival, the walking blood bank was activated, and this patient was replenished with blood and later transferred to Level III. TQ Surgical’s proximity to the front line along with its surgical capacity gave this Soldier, along with many others, a second chance

MEDEVAC from TQ Surgical

Post-operatively, the patients are placed into what is called a “hot pocket,” traditionally known as a body bag. Due to the decreased temperatures in the CH-46, and usual hypothermic state of a trauma patient, the “hot pocket” is lined with a wool and space blanket for added warmth. There is a hole cut into the bag where the patient’s head would be. Medications are drawn up and kept at the ready for continued sedation, pain relief, and paralysis of the ventilated patient in flight. After a short,



A hole cut in the “hot pocket” leaves only the face visible.



A MEDEVAC team maintains ventilation and ensures a safe and expedient transport to the next level of care.

but turbulent ride in the back of a dark ambulance, we arrive at the flight line.

As personnel place the litters onboard, the air crew carefully monitors every movement. From this point on, the crew chief maintains situational awareness within the aircraft.

The darkness in the cabin adds to the realm of uncertainty, but these thoughts are quickly pushed out by the monitor's amber lights—the only real, but not always reliable, link with the patient's status. Critical interpretations, based on keen assessments and vital signs, must be made by the ERC provider to determine in-flight clinical decisions. Light integrity is essential during night missions to avoid alerting enemy to our position, but, without some type of light source, it is virtually impossible to assess the intubated patient and provide interventions. The idea of having to treat the patient as if they were in an intensive care unit is almost inconceivable. ICUs lack the added stress of excess wind, vibration, and noise and ICU personnel do not have to contend with being shot at while trying to deliver patient care.

During an in-flight transfer, basic skills become the primary assessment tool if the monitors fail. Palpation of the carotid pulse and inspection of chest rise and fall may be the only true indicators of a patient's status while in flight. A ventilator bag and oxygen may be the only resort if an endotracheal tube is dislodged or the ventilator fails. The administering and recording of medications becomes the next challenge, especially when using a single light source, all while travelling at 130 knots in the dark.

The hospital is located in the middle of what seems to be a bustling part of the city. With the help of the corpsmen and Level III medical staff, the critical patient is transported into the facility with all of the accompanying medical equipment. Due to the possibility of limited fuel, sniper activity, or other hostile actions, the air crew stresses a quick turnover of the patient for rapid departure. The average turnover and equipment retrieval time is approximately 5-10 minutes at most. The corpsman abruptly cuts short any lingering, urging a quick return to the "bird."

The return flight is always the time to reflect on your performance and hope the best for the patient. The initial excitement has faded, yet thoughts of sustaining enemy fire remain in the back of your head. The cool air, white noise of the engines, and vibration now comfort you, instead of being a hindrance. Each flight is a new learning experience and just as rewarding as the last. One cannot help but gain a feeling of satisfaction from doing your best.

Qualifications

The CASEVAC corpsmen receive more formal aviation training prior to deployment, and are assigned to the squadron on flight orders. In contrast, the ERC providers only receive a short didactic course about general in-flight care and aviation basics. Additionally, they are not on flight orders, and are assigned to the SSTP. No one ordered the CASEVAC or ERC providers to be part of a mission to fly in a combat zone. They all volunteer for these missions and are fully aware they will be risking their lives to do whatever is humanly possible to save our wounded troops. □

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Navy Surgical Team 1965-1966 Vietnam Then and Now A Surgeon's Retrospective

Tom Eblen

When he was sent to South Vietnam in 1965, LT Bill Gondring had no idea that he was beginning what would become a 40-year odyssey. As a young surgeon with 1 year of internship and 1 year of surgical residency, Gondring was rarin' to go. Where he went was Rach Gia, an outpost in the Mekong Delta not far from the end of the Ho Chi Minh trail. What he found was an antiquated, 450-bed hospital and a compact American medical team that became like family.

The team leader, LCDR James Beeby, MC, did half the surgery, and Gondring did the other half, often at the same time. Two nurses, LCDR Ruth Pojcky and LCDR Bernadette McKay, kept the operating room and the recovery room humming. Sharing in the duties were CAPT Lawrence O. Bearson, NC, USAF, a nurse anesthetist, and HM2 William G. Sweeney, an X-ray/laboratory technician. This Navy surgical team was transferred from the Department of Defense to the Department of State, U.S. Agency for International

Development (USAID), for pay and administrative purposes. The team functioned in civilian clothes for the first half of the tour and then in their khaki military uniforms.

There was no formal USAID civilian casualty reporting system. Military casualties were reported and

medevaced via the Third Field Army Hospital Saigon. USAID provided medical logistics within the Vietnam government supply system. Catholic World Charity provided additional humanitarian support. Vietnamese civilian surgical care was the primary mission of the surgical team with the



The hospital at Rach Gia with outside sanitation system in trenches.

Photos courtesy of the author

secondary mission of surgical care for the Military Advisory Command Vietnam (MACV) Advisory Team 54, the local USN Brown Water Navy, the VC and Vietminh forces as well as the Government of Vietnam Regional, Popular forces, and ARVN (Army Republic of Vietnam).

Like most Americans at that time, Gondring went to Vietnam with relatively little knowledge of what he would be facing. “We really had minimal preparation,” he told a Navy historian in an interview last year. He had heard hardly a word about the diseases he would expect to see in the stifling humidity of Vietnam.

As a key member of a team that was put together to provide healthcare, Gondring says, he was left with more questions than answers. “How do you take care of typhoid perforations? How do you treat cholera? How do you take a land mine casing out of a guy who is eviscerated? How are you going to handle patients when you run out of antibiotics? How do you operate at night when the power goes off?” They figured it out. When the power went off in the darkness, they revved up the jeep to activate the generator.

And Rach Gia, off in the southwest corner of Vietnam, tested the American surgical team. Patients didn’t come in on the hour or half-hour. They came in groups, sometimes dozens of men, women, and children. They came at all hours—after bombing raids, firefights, or as victims of mines. As many as 80 percent were Vietnamese, and some were wounded prisoners of war.

The hospital had Vietnamese surgeons, too, but the American team worked separately. That didn’t concern Gondring at the time, but in retrospect, he regretted the missed connection.



Navy surgical team from left to right: LCDR James Beeby, LCDR Ruth Pojcky, LCDR Bernadette McKay, CAPT Lawrence Bearson, USAF, NC, LT Bill Gondring, HM2 William Sweeney.

“We did not work within the Vietnamese system and their style of doing things,” Gondring says. “We didn’t explain our instruments and our techniques and then have a dialogue about their instruments and their techniques. Our senior leadership, including myself, never knew that we should have integrated ourselves into their system. We could have been more successful on levels other than operating, amputating, and removing kidneys, if we had an opportunity to bond over common experiences and learn about their life and then integrate and teach.”

There was, therefore, no USAID or military directed process to build a surgical infrastructure to enable the indigenous surgical personnel to assume the surgical care, maintenance, and supply system for surgical care at the Rach Gia Hospital.

Nurses McKay and Pojcky shared vivid memories of that time in an article published in the November 2004 issue of *NNCA News*.

“Most of us have to agree that our most memorable experience was the

36-hour period when we admitted 160 patients and performed 27 major surgical procedures,” they wrote.

“About 10 one morning an American helicopter gunner walked into our emergency room with a through-and-through gunshot wound of his face. He had been aboard a ‘cover chopper’ for a ‘dust off.’ An air-evacuation chopper had gone in to pick up three patients from Kein Binh, a district about 20 kilometers from the hospital. The soldier’s wound was minor, but his information was spectacular. He told us we might be getting busy because ‘There was one (expletive) of a firefight going on down there, Doc!’ To say the least!

The patients from the firefight began arriving about 11:30 and continued to arrive in trucks, ambulances, choppers, and cycles, and in groups of 3 or 10 until about 3:00 the following afternoon. Luckily, we had with us at that time two extra surgeons.”

The doctors and nurses didn’t stop for more than 24 hours, exhausting themselves and pushing to its limits their one autoclave, which sterilizes

surgical instruments so they can be reused.

Gondring spent the year 1965 doing what surgeons do in combat zones. "There was a whole lot of cuttin' goin' on," he recalls. And stitching. And debridement, especially debridement, which is the surgical removal of dead or contaminated tissue and foreign matter from wounds. It was and is the surgeon's first line of defense, especially in wartime when supplies are limited.

For a physician whose specialty was orthopedics, Gondring had his share of bone cases, especially amputations, but he also did half the general surgery. "The general surgeon was doing the more complicated cases," he says. "I was doing the more simple cases like abdominal explorations. We got to where we could do an amputation in 14 or 15 minutes."

The Rach Gia hospital was inundated with patients after a napalm raid enveloped women, children, and old men who had been living nearby with the Regional Popular Forces.

"We took care of that whole group," Gondring says. "Every patient was treated the same. They'd be on a gurney. Their wounds would be debrided. They would receive penicillin, chloromycetin, tetanus, then morphine. Then you'd debride and apply a yellow sulfa preparation. We had no dressings, so we cut up parachute silk."

And if they ran out of room, "The hospital could be expanded by pushing the beds together," Gondring says. "You could have three children in one bed with two in traction. When we had so many patients on the ward that it would overflow, we'd roll the beds together. You might have two and three patients in a bed."

Like soldiers from time immemorial, Gondring's medical team impro-

vised. They had a lot of fractures, so they did a lot of traction. Ace bandages were wrapped around cut bicycle tires with a piece of wood on the end and a parachute line for holding the weights. There were no metal pulleys, so carpenters hand-carved wooden pulleys.

After 13 months, Gondring left Vietnam, but Vietnam didn't leave him. He finished his active duty on orthopedic ward service at Naval Hospital Great Lakes. In the 1970s he moved to Lincoln, NE, where he was an orthopedic surgeon and chief of the prosthetic clinic at the Veterans Administration Hospital. He worked with many Vietnam veterans including Bob Kerrey, a man who would become a powerhouse politician.

But the gravitational pull of home brought Gondring back to his birthplace, St. Joseph, MO, as an orthopedic surgeon in the late 1970s. He stayed in the Navy Reserve, rising to the rank of captain. He made volunteer medical trips to Central America and Croatia, but Vietnam was never

out of mind. And, unlike many American veterans who couldn't wait to get out of Vietnam, Bill Gondring couldn't wait to go back.

His opportunity came through the American Orthopaedic Foot and Ankle Society (AOFAS), also supported by the Prosthetic Outreach Foundation. The commitment was to send a team of surgeons to do foot and ankle surgery at three hospitals in Vietnam. The AOFAS has committed to Vietnam four AOFAS international fellows each year since 2002. The primary mission of the AOFAS is to teach and promote understanding of the foot and ankle. Two surgeons serve for a period of 2 weeks each year at Vinh and Hanoi, for a total commitment of 5 weeks, featuring an annual American-Vietnamese specialty conference on foot and ankle disorders.

Dr. Pierce Scranton of Seattle, the 2001 president of the AOFAS, signed on immediately. Also on the team were Dr. Naomi Shields of Wichita, KS, and Dr. Ruth Thomas



Dr. Gondring making rounds with Vietnamese nurse.



2003 American Orthopaedic Foot and Ankle Society International Fellows surgical team. From left to right: Drs. Pierce Scranton, Naomi Shields, Rob Veith, Ruth Thomas, Bill Gondring.

of Little Rock, AR. The sole Vietnam veteran was Dr. Bill Gondring of St. Joseph.

The return was October of 2003, and it was eye-opening. The four American physicians were to provide 3 weeks of clinical, teaching, and surgical experience culminating in a national American-Vietnamese Foot and Ankle conference in Hanoi. There are 500 orthopedic surgeons practicing in Vietnam; over 100 attended the first AOFAS foot and ankle meeting in Hanoi, in 2003.

How things had changed. The case load was cut in half. Two-thirds of the Vietnamese patients were pediatric as opposed to 20 percent in 1965. The four American surgeons worked cooperatively with 10 Vietnamese surgeons. More than half the 1965 surgeries were a consequence of war, and only 21 percent were elective. In 2003, all surgeries were elective.

They were elective only in the sense that what they sought to fix wasn't life-threatening. As Scranton explained later, the medical principles for the group were first to do no harm and then to do the greatest good for the greatest number of people.

Vietnamese physicians had screened 50 patients so that the American surgeons could focus on those in greatest need. That helped, but ultimately it didn't matter. Nearly 70 showed up because the word had gotten around. It meant for a long but satisfying day.

In some easier cases, children with rickets simply were given vitamins. They didn't need surgery. But polio was rampant. Scranton estimated that on that day alone the four American surgeons had seen more polio cases than exist at this time in America.

In a particularly challenging case, the American doctors saw a young woman whose right foot appeared to be on backward. Ten years before,

she had been bitten by a pit viper. As Scranton observed, that case and others had not been described in conventional medical textbooks. The great advantage of the surgical team was that the surgeons could work together for the best outcome. In Scranton's words, "the pit viper bit to the lateral side of her foot. The deformity 10 years later was not seen in any textbooks, and Bill and I had to figure out what was going on and develop a strategy to treat it." Amputation was the answer. The young woman would live a more productive life with a prosthetic leg.

Scranton continues, "Watching his eyes light up treating disabled children and operating with a former [NVA] jungle surgeon who was an enemy 37 years ago, both of them working together to correct a disabled child's leg, was something special."

Any reservations that Gondring might have had vanished in the regional hospital at Vinh where he operated with Bac si (Doctor) Linh, whose forearm still bore the tattoo of the Tiger battalion of the North Vietnamese Army. In Gondring's words, "We were two physicians operating on the same patient, directed toward the same outcome." Linh summed it up succinctly: "That is the past, and this is the future."

Indeed, Gondring had come full circle. Not only had he come back to Vietnam but also Vinh.

For Gondring, though, the full circle wasn't enough. His 2003 surgical team also evaluated patients who almost certainly had been victims of Agent Orange, either directly or by inheritance. Between 1962 and 1971, U.S. forces sprayed 20 million gallons of the herbicide known as Agent Orange to remove foliage that provided cover for enemy forces. After their service in Vietnam, some

U.S. veterans reported a variety of health problems that they attributed to Agent Orange.

So the diagnosis of Agent Orange wasn't hard. Gondring says, "We knew it was Agent Orange because you never see patients with no arms, no elbows, no shoulder joints. Dioxin causes chromosomal aberrations. No one knows what the dose level is for chromosomal aberrations from dioxin.

"In my entire experience working at Shriners' Hospital for Crippled Children, I never saw these cases. So you have to suspect there was an environmental reason causing it."

As Gondring's colleague, Naomi Shields, says, "I think Bill has memories from the 60s and that his trip to Vietnam helped put many of them either to rest or in perspective."

For Shields, a moment that stood out was Gondring's presentation on how to measure compartment pressure to 100 Vietnamese orthopedic surgeons. "He had such enthusiasm and earnestness," she says. Gondring had wondered how he would be greeted as one who had been a medical officer for the U.S. 40 years ago. He found 180 degrees of difference. He was welcomed as a professional colleague. And he felt safer than he does in downtown Kansas City, a far cry indeed from being shelled in 1965.

As he recalls the so-called "Hearts and Minds" campaign when he was in Vietnam, Gondring laments that it was destined to fail because of our arrogance and ego. "I always felt that I wasn't arrogant because I was sent to Vietnam," he says. "But in reality I was arrogant and had an ego or else I would have insisted on having the Vietnamese physicians scrub with me and collegially discuss decisions on health care, ER coverage, rounds, and medications."



Bác sĩ (Doctor) Linh and Dr. Gondring 40 years later.

That wasn't the case in 2003. The American surgeons went to Vietnam with the goal of sharing what they knew with fellow physicians, and they were welcomed with open arms in a collegial sharing system of providing foot and ankle surgical care within their own indigenous surgical system.

"After 40 years, the character of the people was the same, but almost everything else had changed," Gondring says. Now that I am older and wiser, I understand the epic national struggle that had occurred in the war, the hope that has persevered, and the economic equality and social justice that has resulted in Vietnam.

"I am proud to have been a part of it all," he says, "for it has changed my life beyond measure."

In the end, the Navy surgical team provided humanitarian care to the wounded and injured civilians of the war in Vietnam. The American Orthopaedic Foot and Ankle Society outreach mission to Vietnam provided humanitarian care to the disabled patients and promoted education and understanding of the foot and ankle to the orthopedic surgeons at Vinh and Hanoi. □

Mr. Eblen is a retired editor of the *Kansas City Star* and is now a consultant for the Kansas Press Association.

The Naval Legacy of the “House of Squibb” “Battle Stations (1859-1945) Part II

James M. Schmidt

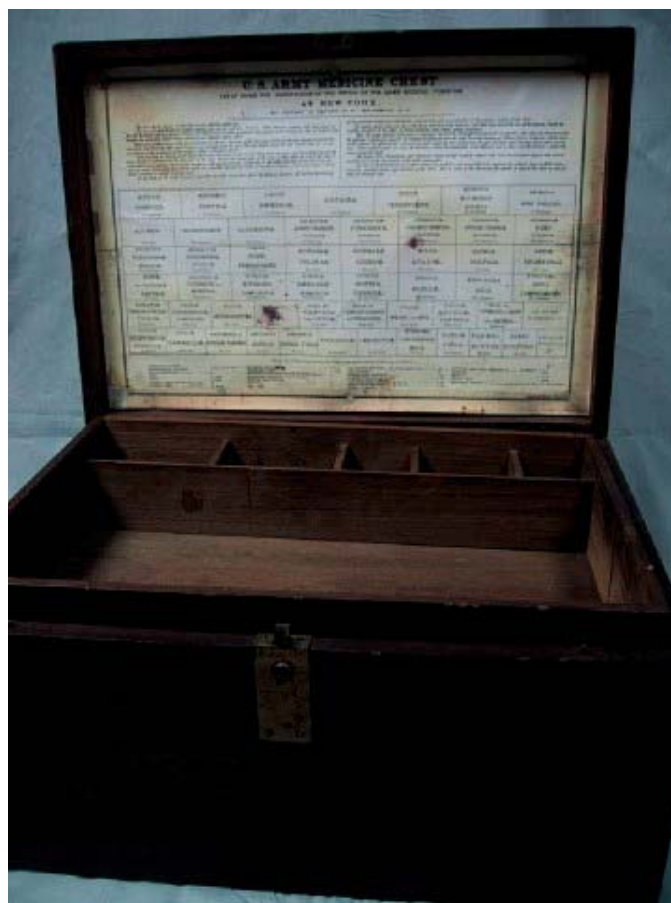
Only a few weeks after the fire, and still recovering from serious injuries, Squibb found the strength to dictate a short letter, published in *American Journal of Pharmacy*, describing the circumstances that had left his nascent enterprise in ashes. As he explained it, a boy—new to the firm—accidentally broke a small bottle of ether and the fluid spilled near a flame the young man had been using to wax stoppers. He cried for Squibb, who upon arriving found “the whole table and a portion of the floor in a voluminous blaze.” Squibb tried to extinguish the flames, nearly succeeding, but soon found himself trapped behind the fire without a safe exit. He quickly grabbed some journals and research notebooks, and “took the longest possible run, closed [his] mouth and eyes and jumped through it.” By the time he reached safety most of his clothing had been seared away and his face and hands were burned horribly.⁽¹⁾

Insurance covered all but nearly a thousand dollars of the losses, so that while Squibb recuperated, the landlord rebuilt the damaged floors and mechanics refitted the laboratory with

apparatus and fixtures. At the same time, a group of distinguished physicians subscribed more than \$2,000 to help. The men offered the money as a gift, insisting, “...we look upon your cause as our cause,” but Squibb eventually returned the money with interest. By the end of 1859, the laboratory was again in operation, and upon the outbreak of the Civil War Squibb was in a position to meet many of the Union Army’s medical needs.⁽²⁾

Indeed, Squibb stood as one of the most influential drug makers during the war years. He consulted with the army on its standard supply table, and without

compromising his strict standards of quality, Squibb filled the army’s orders as quickly as he could, working day and night and hiring additional



Civil War “Squibb pannier.”

Photos courtesy of DrumBeatMilitary

hands. In 1862, he bought additional land in Brooklyn, near the Fulton Ferry, and built and equipped an expanded laboratory to meet the army's needs.(3)

One of Squibb's more useful war-time innovations was the introduction of his "medicine pannier," which helped to standardize the distribution of medicines to individual units and to make their use more convenient. In addition to medicine wagons, the Union Army used large, heavy boxes to carry drugs and supplies while on a campaign. These containers had to be transported in supply train wagons, and were thus generally unavailable to surgeons during an engagement. Squibb's pannier was constructed of iron-reinforced wood and equipped with robust iron handles sturdy enough to withstand the rigors of march, yet compact enough to be carried in an ambulance or by a horse or mule to aid medical staff closer to the front lines. The pannier was divided into two tiers, with bandages, surgical instruments, and other supplies stored in a removable upper tier, while the lower tier contained medicines. Each pannier contained nearly ninety items, from "A to Z" (*argenti nitrates to zinci sulphas*). A diagram on the inside of the chest lid, showing the location of each item, made retrieval of a specific medicine very convenient.(4)

Squibb may have also supplied Rebel surgeons with medicine, at least indirectly. The Confederacy maintained at least one navy medical laboratory and no less than eight army laboratories, primarily dedicated to manufacturing rather than research. The successful Union blockade forced the Confederates to rely on blockade running, smuggling, and capture of Union supplies to meet its medical needs. Years after the war,

Squibb's son Charles was quoted as saying that "our chief distributor [in the South] was General [Nathaniel] Banks. The Johnnies always managed to capture his well-equipped trains. Our goods went all through the Confederacy and were appreciated." In a letter that accompanied his \$128 check to Squibb, Thomas Smith, a pharmacist from St. Joseph, MO, speculated that his missing shipment of medicine was due to the "the rebels...having their way in Missouri."(5)

The combination of overwhelming casualties and the loss of supplies to the rebels prompted Satterlee to persuade Squibb to expand his operations even more. Squibb was uncertain that he could give the larger plant the close personal attention required to maintain the quality of his products, and doubted that postwar orders from a presumably smaller standing army would justify the expense and risk of another expansion. Over Satterlee's objections, Surgeon General William A. Hammond proceeded with plans to set up Army laboratories, one in Philadelphia and another in Astoria (Long Island), just miles from Squibb's.(6)

Disappointed in the potential loss of contracts, Squibb was also dubious of the talents of Charles McCormick, Hammond's choice to direct the Astoria lab, having once referred to McCormick as "little more than a great quack." Nevertheless, Squibb invited Hammond to send an observer, offering "free access to all details and operations of my laboratory." A young medical officer, Joseph H. Bill, spent several months with Squibb and eventually replaced McCormick at the Astoria lab. John M. Maisch, an erstwhile Squibb employee and talented chemist, headed the Philadelphia lab.(7)

Between the end of the Civil War and Squibb's death in 1900, his laboratory thrived. During the last years of his life, he left management of the firm to his sons, Charles and Edward, and in 1895 the firm was renamed "E.R. Squibb & Sons." The company supplied huge quantities of anesthetics, arsenicals, and other drugs for the doughboys fighting World War I and earned an "Award for Distinguished Service" for its production efforts.(8)

A near century-long tradition of supplying the armed forces, coupled with considerable scientific and production expertise, left the "House of Squibb" well prepared to meet the challenges and demands of World War II. As early as 1939, company officials consulted with military authorities on tentative wartime production plans and selected facilities were enlarged to ensure sufficient capacity to meet future emergencies. When America did enter the war, E.R. Squibb & Sons became one of the largest single suppliers of medicinal products to the Army and Navy, providing more than a hundred different products, again almost literally from "A to Z": arsenicals, chloroform, digitoxin, ether, methyl bromide, plasma, quinine, sulfa drugs, vaccines, and dozens more.(9)

In addition to increasing production of products to meet military demands, the company also pioneered innovations that proved especially significant in combating pain, shock, and infection on the battlefield and at sea. The Squibb morphine syrette, introduced just before the war began, was used with great effect to treat the wounded at Pearl Harbor and was employed in most land, sea, and air engagements through the end of the war. The syrette—a small, collapsible tube fitted with a sterile hypodermic

needle—provided an ideal solution to the conflicting requirements of protecting narcotic preparations from pilferage by addicts, while at the same time providing for the ready availability of morphine in an emergency, when time did not allow for the preparation of hypodermic solutions.(10)

During the war, combat medics and corpsmen administered single doses of morphine on the front lines. The “½ grain” injection from the convenient syrette, combined with physical exhaustion, was sufficient to block the patient’s pain in minutes—providing relief until the patient could be hospitalized. The syrette was then sometimes pinned to the casualty’s clothing to alert other caregivers that the patient had already received the drug.* Squibb scientists also contributed to the large-scale production of “normal serum albumin,” an important plasma substitute, as well as the manufacture of penicillin.(11)

Beginning with their founder’s Navy career, Squibb company officials and line employees have a strong tradition of active participation in America’s wars. Lowell Palmer, who with Theodore Weicker bought control of E.R. Squibb & Sons in 1905, fought in the Union Army for 4 years, during the Civil War. Palmer’s son, Carleton, left the presidency of the company in 1917 to serve as an artillery officer in World War I. At the outset of World War II, Weicker’s son, Lowell, left the presidency of the company to serve as an officer

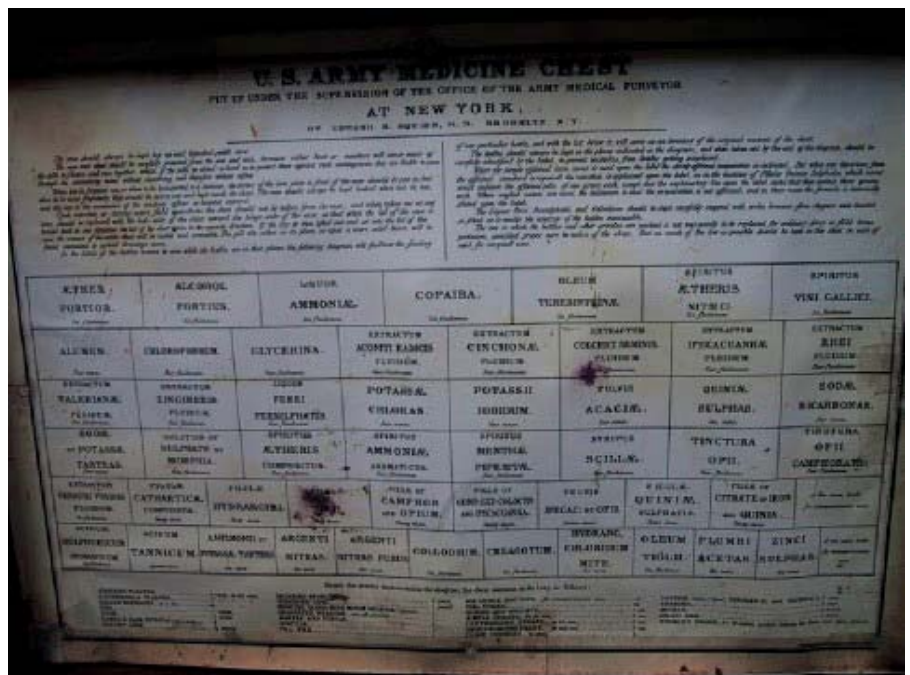
in the Army Air Forces. At the same time, no less than 500 Squibb employees joined the armed forces, and hundreds of others served in various government capacities.(12)

No wartime Squibb employees would have argued that their jobs were more dangerous than those of the Soldiers and Sailors they supplied, but that is not to say their work was risk-free. Squibb technicians responsible for preparing typhus vaccine for the troops handled the virus daily, risking serious illness. Others filled methyl bromide ampules (used as a delousing agent), a hazardous process that required handling the volatile liquid at 90 degrees below zero, then sealing the container with a hot flame; several workers suffered painful burns from the extremes in heat and cold. The importance of the Squibb factories, coupled with their location on the vulnerable eastern seaboard, required precautions such as periodic blackouts and air raid drills. The Army even constructed a

barracks and a gun platform at one of the Squibb plants, presumably to be manned by one of its Coastal Artillery Battalions.(13)

Squibb also did its part in bolstering morale on the home front. In late 1940, the company sponsored a weekly program, “The Golden Treasury of Song,” on CBS radio stations to promote its Squibb Dental Cream. The program featured Victor Bay’s orchestra and the voice talents of Jan Peerce and Frank Parker. Noted opera singer Walter Cassel joined the program in late 1942 when Parker was called into the Navy. Soon after the war started, Squibb changed the program’s name to “Keep Singing, Keep Working, and Fight for America!” The program was popular, so much so that the government borrowed Squibb air time to deliver war messages on several occasions. The program won a *Variety* award for “consistently supporting the war effort and national unity in imaginative and effective ways.”(14)

*The corpsman’s standard medical kit of the time contained a grease pencil which allowed the care giver to write an “M” on the patient’s forehead, indicating that morphine had already been administered.



Lid of the Civil War pannier.



"First Aid to the Fallen" by Irwin Hoffman shows a corpsman administering a morphine syrette.

On 18 September 1942, RADM Harold W. Smith, the chief of the Research Division of the Bureau of Medicine and Surgery, presented an Army-Navy "E" flag to Squibb chairman Carleton H. Palmer to recognize the company's production efforts. The company employee's celebrated the honor with a banquet at the Waldorf-Astoria Hotel in New York City and broadcast the ceremonies on more than 50 CBS radio stations. The company earned three additional stars for the flag over the course of the war.⁽¹⁵⁾

The naval legacy of E.R. Squibb & Sons came full circle when a liberty ship, SS *Edward R. Squibb*, was launched 9 November 1944, at the J.A. Jones Construction Co., yards, in Brunswick, GA. George S. Squibb, Jr., great-grandson of the founder, and a Squibb employee himself, operated the switch that released the 10,500-ton vessel. As part of the ceremonies, Squibb gave an account of his great-grandfather's

service in the Navy, and his important contributions to the standardization of drugs.⁽¹⁶⁾

The Squibb Corporation merged with Bristol-Myers in 1989, forming one of the world's largest pharmaceutical companies. Bristol-Myers Squibb (BMS) is headquartered in New York City, with employees in more than 200 countries. BMS spends more than \$2 billion each year on research, and grosses more than \$18 billion annually in sales of products such as *Excedrin*®, *Pravachol*®, and *TAXOL*®. America can be thankful that E.R. Squibb & Sons has consistently answered its unique and important call to "Battle Stations" for more than a century.⁽¹⁷⁾

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In Memoriam

LCDR Wheeler B. Lipes, MSC, USN (Ret.) World War II pharmacist's mate and submariner, died on 17 April 2005 in New Bern, NC, after a long battle with cancer. He was 3 months shy of his 85th birthday.

Known as "Johnny" to his friends, Lipes was born in New Castle, VA, on 12 July 1920. He became involved in health care as a teenager while helping his mother provide home nursing to a chief petty officer's wife at the Naval Base in Norfolk, VA. As a 15-year-old, Lipes also worked at the Naval Air Station dispensary serving meals to patients, working in the pharmacy, and typing patient records and other documents. As he recalled in a 1993 interview, "I was learning all the time and knew exactly what I wanted to do." Lipes gained fame in 1942 by performing the first emergency appendectomy ever attempted aboard a submarine.

Wheeler Lipes dropped out of high school and joined the Navy at age 16 during the worst years of the Great Depression. Years later he would obtain his high school diploma through the GED (General Educational Development program), attend The George Washington University, and earn a degree.

He went through basic training in Norfolk, VA, and was assigned to Hospital Corps school at San Diego for further training. During the voyage to the West Coast, he served as a crewman aboard the ammunition ship USS *Nitro* (AE-2).

When he graduated from corps school in 1937, Lipes was assigned

to the battleship USS *Texas* (BB-35), where he worked as a pharmacy technician. The Navy of the 1930s was not many generations removed from the sailing ship navy of the previous century, and a sailor's life resembled that of Lord Nelson's era aboard HMS *Victory*. He recalled: "The gun deck was a mess deck. The long baronial-type mess tables with folding steel legs could be hung up from the ceiling on some hooks. Once that table was hung in the overhead, the area was all empty like a big room and was ready to receive casualties or whatever was necessary when an engagement was being fought."

Following his service aboard *Texas*, HA1c Lipes joined the staff of Naval Hospital Philadelphia in July 1937. There he worked as a ward corpsman, was trained as an EKG technician, and earned a promotion to PhM3c.

In 1940, he was transferred to Naval Hospital Cañacao in the Philippines where his skills as an EKG technician were quickly recognized. By age 21 he had already advanced to the rate of Pharmacist's Mate First Class, an unusually fast track for the pre-war Navy.

Tropical duty was good for both the enlisted and officer ranks. "We had what was known as 'tropical



working hours.' You worked from 7:00 until 11:30 in the morning and stood a watch every seventh day. People went to work at 7:00 and were leaving early at 10:30 in the morning." Such an assignment, however, soon grew boring for an ambitious young corpsman, and Lipes asked for duty aboard submarines. He was then transferred to USS *Sealion* (SS-195), becoming an independent duty corpsman and the sub's only trained medical professional.

On 10 December 1941, war came to the Philippines when Japanese bombers reduced the Cavite Navy Yard to rubble and killed several hundred U.S. servicemen and Filipino yard workers. *Sealion* and her sister sub, USS *Seadragon* (SS-194), were at one of the yard's piers undergoing overhaul. A direct hit on *Sealion* sent her to the bottom and another bomb caused death and injury on *Seadragon*. Lipes sustained shrapnel wounds in his arms and legs. But within hours he was reassigned as *Seadragon*'s corpsman when that boat's pharmacist's mate checked into the naval hospital for treatment of his wounds.

Following repairs to her punctured pressure hull and conning tower, *Seadragon* began aggressively patrolling Philippine waters seeking Japanese targets for her torpedoes. After Bataan fell in April 1942, the submarine continually ran the Japanese blockade of Manila Bay delivering sorely needed food and supplies to Corregidor's besieged defenders. When that island fortress finally surrendered to Japanese forces in May, *Seadragon* began patrolling the South China Sea. It was on one of these patrols that PhM1c Lipes encountered the situation that would make him a Navy legend.

Seadragon was well into her fourth combat patrol when a crewmember began showing symptoms of acute appendicitis. After carefully monitoring his patient, Lipes advised the submarine's commanding officer that the seaman's condition was worsening and that an operation was required to remove what was undoubtedly an acute appendix. The sub was then in enemy-controlled waters and medical evacuation was deemed impossible.

Seadragon's skipper then ordered his pharmacist's mate to perform the surgery. It was 11 September 1942. Although Lipes had assisted in several appendectomies while on shore duty, he was not a physician. Nevertheless, he set to work gathering his operating team.

With the ward room dining table serving as the operating table, Lipes commenced the operation using items procured from the galley for instruments. Bent tablespoon handles served as retractors, a tea strainer with gauze became an anesthesia mask, and ether he had stored aboard served as the anesthetic. Prior to the operation, all instruments had been sterilized by being boiled in water.

The rubber gloves and pajamas used as operating clothing were sterilized with alcohol normally used to fuel *Seadragon's* torpedoes.

As it turned out, the location and removal of the appendix was anything but routine. It was hidden from view--tucked under the blind gut and adhered to the intestine. Lipes had to detach the appendix, being careful not to cut or puncture it which would have flooded the lining of the abdominal cavity with its infected contents. He then removed the appendix and concluded the operation about 2 ½ hours later. In a few days, Seaman Darrel Rector was back on duty showing no adverse effects from his historic surgery.

Related in a 1942 article in the *Chicago Daily News*, the story brought a Pulitzer Prize to journalist George Weller and fame to Pharmacist's Mate Lipes. It also gave a much needed dose of inspiration to the home front when good news about the war was hard to come by. The submarine appendectomy was later immortalized in the films "Destination Tokyo" and "Run Silent, Run Deep," and also in "The Silent Service," a television series of the 1950s.

After his tour aboard *Seadragon*, Lipes returned to Naval Hospital Philadelphia in 1943. He was there but a short time before being commissioned as a chief warrant officer and detailed to the School of Hospital Administration in Bethesda, MD. After completing the course, he returned to Philadelphia and worked in finance and as a pharmacy officer.

Three years later, he was transferred to the 2nd Marine Division, Fleet Marine Force Atlantic as a supply officer and then administrative assistant to the Division Surgeon. He left that assignment in 1949 and transferred to Naval Hospital Portsmouth,

VA. In 1951, while serving there, Lipes was commissioned an ensign in the Medical Service Corps. His duties were as a finance officer, and after attending the School of Naval Justice in Newport, RI, he also served as a legal officer defending personnel in court martial proceedings.

In 1954, he was assigned as a finance officer at Naval Hospital Quantico, VA, where he was promoted to the rank of lieutenant, junior grade, and remained there until 1956 when he was assigned to Headquarters, Potomac River Naval Command and the Naval Gun Factory in Washington, DC.

From 1958 to 1960, LT Lipes was on the staff of U.S. Naval Hospital Guam as legal officer and supply officer. His last assignment in the Navy was chief of the Fiscal/Supply Division at Naval Hospital Memphis, TN, where he served from 1960 to 1962.

After he retired from the Navy in 1962, Wheeler Lipes became Administrator of the West Tennessee Chest Disease Hospital, where he served until 1970. From 1970 to 1978, he was Administrator of the Regional Medical Center, Memphis, TN, the 1,000-bed teaching hospital of the University of Tennessee. He then became Executive Director of that facility until 1979 when he moved to Corpus Christi, TX, to serve as President of Memorial Medical Center. He retired from that post in 1991.

During his 26-year Navy career, LCDR Lipes earned the Purple Heart, the Submarine Combat Device with three stars, the American Theater Medal with one star, the Asiatic theater Medal with three stars, the Good Conduct Medal with one star, World War II Victory Medal, the Philippine Defense Medal, the American Defense Medal, and the National Defense Medal. In February 2005, he

was awarded the Navy and Marine Corps Commendation Medal for his action aboard *Seadragon* in saving the life of Darrel Dean Rector.

From age 15 until the very end of his life, Johnny Lipes considered himself “a child of the Navy.” He began his career when battleship sailors still strung hammocks to sleep in and holystoned teak decks until they gleamed in the

sun. He was also a self-made man in the Horatio Alger tradition. Brought up in very humble circumstances, he was an eager learner who rose through the Navy ranks and later, as a civilian, became leader of two major city hospitals. As a member of the “Greatest Generation,” he served his nation with dedication and pride. Like many other Navy hospital corpsmen who have gone to war and held the lives of their comrades in

their hands, Johnny Lipes always remained humble. He never saw himself a hero for performing the operation aboard *Seadragon* back in 1942 and always downplayed his role. “I did what I had to do to save a man’s life. Darrel Rector was the brave one.” Those who knew and admired Johnny Lipes will miss him very much. □

RADM W. David Sullins, Jr., MSC, USNR, (Ret.) former Navy medicine leader and respected primary eye care clinician, died on 6 February. he was 63.

Dr. Sullins was born on 3 August 1942. He joined his father in private practice in 1965 and in May 1967 volunteered for service as an optometrist in the Navy. He also served with the Marine Corps. He was the President of Sullins Family Eye Care Clinics, PC of Athens, Madisonville, and Etowah, TN.

As a naval officer and optometrist, RADM Sullins was the first optometrist in any service to be selected for flag rank, and the first reserve Medical Service Corps officer to be selected for rear admiral. The Association of Medical Service Corps of the Navy (AMSCON) created the RADM Sullins Award to be given to the most outstanding junior officer in the Medical Service Corps. He served as AMSCON’s first president in 1988. After many challenging commands and major staff assignments, including the Bureau



of Medicine and Surgery and the Pentagon, he retired from the Naval Reserve as a rear admiral.

Professionally, Dr. Sullins served as President and Speaker of the House of Delegates of the American Optometric Association. He was awarded the AOA Distinguished Service Award, and was a founding member and Distinguished Practitioner in the National Academies of Practice. A Fellow in the American Academy of

Optometry, he chaired the committee on ethics and was recipient of the Carel C. Koch Medal for inter-disciplinary activities. He was also an adjunct professor at his alma mater, Southern College of Optometry, which bestowed upon him an honorary Doctor of Ocular Science degree. Dr. Sullins was an adjunct faculty member at the College of Optometry, University of Alabama, and a member for 9 years and chair for 5 years of the profession’s accrediting organization, the Accreditation Council on Optometric Education.

Memorial donations can be made to the Dr. William David Sullins, Jr. Scholarship Fund, c/o American Optometric Association, 243 North Lindberg Blvd., St. Louis, MO 63141-7881, or The Rear Admiral Sullins, Jr, MSC Scholarship Fund (SCH-120), c/o The Virginia Beach Foundation P.O. Box 4629, Virginia Beach, VA 23454. □

—Written by CAPT Robert Younger, MSC, USN, Reserve Affairs, M09BMSCR, Bureau of Medicine and Surgery, Washington, DC.

Letter to the Editor

In "Buzzing the Doctor's House" (*Navy Medicine* Vol. 96, No.3, May-June 2005, pp.32-33) a photograph illustrates the article about CAPT Copeland's wartime experiences in Vietnam's Mekong Delta during 1967. The photo, however, was taken in the Hoa Khanh Children's Hospital near Danang, at the other end of South Vietnam, sometime between July 1969 and June 1970.

The nurse in the picture is Nguyen thi-Khang or "Nurse Gwen," Chief Nurse of the Hospital, a remarkably able, intelligent and dedicated professional who was forced to flee her home city of Hanoi in the wake of the Communist takeover. She subsequently adopted three Vietnamese children. I know because the "Navy physician" in the photograph is I. My fellow Navy physicians and I were assigned as Battalion Surgeons to the Marine Force Logistic Command at Red Beach north of Danang in I Corps, Republic of Vietnam. During our tour of duty we were also privileged to care for sick and injured Vietnamese children at the Hospital, built by the Seabees and Marine Corps engineers during 1967-8 for that purpose. There, Nurse Gwen supervised over thirty Vietnamese nurses providing superb support and interpretation. We diagnosed and treated a panoply of exotic diseases we never would have encountered back in the States. Medicines and medical supplies were donated by charitable organizations such as the World Relief Commission. We had the pleasure of watching numerous young children restored to health often with but minimal treatment or intervention, and of returning them to grateful parents. On MEDCAP patrol

visits to villages in the area, we took sick call and treated the local populace with the medicines available to us. I grew to know these people and to become fond of them, and I tried to learn some of their language.

South Vietnam at the time was in the throes of civil war. The Vietnamese were all afraid. None of them was ever sure which side of the war their compatriots were on. Those who were courageous enough to ally themselves with the Americans risked their lives in so doing. Viet Cong guerrillas launched multiple rocket and mortar attacks on the Red Beach area while we were there, but the Hospital was never targeted. This was because children of the VC were always included among our patients. We didn't know which ones they were, and we did not wish to know.

A year or so before my arrival "in country" the major American news media organizations convinced themselves that the "bad guys" in Vietnam were not the Communists attacking the South but the Americans attempting to defend it. During my tour the Viet Cong detonated an antipersonnel mine in a crowded Danang movie theater during a show, killing over sixty Vietnamese outright and wounding over three hundred more in an attempt to terrorize the local populace into Communist submission. Some of the children wounded in that attack were treated at our hospital. At this time I had the opportunity to talk with a reporter from one of the

premier American newspapers who was visiting us in search of a story. I related the terrorist assault to him and asked him if he would wire it in to alert the American people back in the States to the ruthless nature of the foe we were fighting in Vietnam. He replied no; his organization wasn't interested in that type of story, but rather he was seeking reportage about American servicemen disaffected by the war or who misbehaved.

Certainly perspectives on the Vietnam War vary even to this day thirty years later. I cannot help but believe, however, that in our Congressional military aid cuts to South Vietnam in September, 1974 and the ensuing fall of Saigon in April 1975, we betrayed many brave people it has been my privilege to know. □

Raymond L. Osborne, Jr., M.D., Hamden, CT.



Book Review

The Discussion of Hospital Ships Continues

We have seen a host of essays on the future of the Mercy-class hospital ships. The debate continues in the Winter 2005 edition of the Naval War College Review. Professor Richard Grunawalt's is entitled, *Hospital Ships on the War on Terror: Sanctuaries or Targets*, (Newport, Rhode Island: Naval War College Review, Winter 2005, Volume 58, Number 1, pp.98-119). I usually feature book reviews but this essay so stirred my thoughts that I highly recommend it to my Navy medicine colleagues. After reading it, you may wish to add your voice and thoughts to the debate over the future of our hospital ships.

Among the many ideas Grunawalt postulates is the essence of international law that a hospital ship does not necessarily have to be painted white, just clearly identified as a humanitarian platform. This distinction is important as we deal with adversaries who are not principled and would attack a hospital ship in the same fashion as the USS *Cole* or the French tanker *Limburg*. Yet, according to the essay, the hospital ship as it is configured today is a valued symbol of America's humanity and a potent moral force.

The author also argues that it is time for the United States to encrypt communications aboard hospital ships. Grunawalt goes a step further applauding the January 2003 decision to provide USNS *Comfort* with this capability but wants the Navy to reaffirm its adherence to the humanitarian purpose of the platform and provide the right of a principled adversary to board and inspect the hospital ship in the presence of a neutral observer. Although not covered in the article, the issue of encryption also touches on the means by

which patient information is exchanged between ships and military treatment facilities via e-mail and ways in which encryption protects a patient's privacy.

Another section of the article argues for arming hospital ships with robust defensive capabilities and a clearer definition of the San Remo's Manual that governs "deflective means of defense" for hospital ships. Having cooperated on force protection issues of Navy assets in the Middle East, I must agree with the author who proposes that hospital ships be equipped with Close-in Weapons Systems (CIWS), a fully automated Gatling gun that shreds an incoming missile or plane within several hundred yards. CIWS or Phalanx is a warship's last line of defense. The author also argues that the San Remo Manual needs to be updated and disagrees with its classification of anti-aircraft guns being offensive in nature.

Grunawalt's essay also points out that if the Geneva Convention and other laws are not revisited to take into account the new reality of terrorism we and our allies are facing, we may want to consider opting out of regulations that are antiquated. The British have invested in primary, casualty, and receiving ships forsaking the traditional hospital ship markings. According to Grunawalt this provides the ability to use encryption and to arm defensively their hospital ambulance ship HMS *Argus*.

This essay is recommended for all those interested in operational medicine and, although one may not agree with Grunawalt's proposals, I urge my colleagues to reflect on his ideas and share your views in the pages of *Navy Medicine*. □

—LCDR Aboul-Enein, Plans, Operations, and Medical Intelligence Officer detailed as Country Director for North Africa and Egypt, and Special Advisor on Islamic Militancy at the Office of the Secretary of Defense, Washington, DC..

Navy Medicine 1920



Physiotherapy room, Naval Hospital Brooklyn, NY.

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